TENNESSEE DAY CARE IMMUNIZATION CERTIFICATE

This form and any attachments must be filed in the child's health records.

I. IDENTIFYING INFORMATION:

Child's Name _____ Birthdate _____

Parent/Guardian's Name _____ Phone No. _____

Address _____

II. IMMUNIZATION REQUIREMENTS (for children 8 weeks and older):

Children attending child care must be immunized age-appropriately according to the schedule approved by the Commissioner of the Department of Health. See Below:

Vaccine	Usual Age When Immunized				
	2 months	4 months	6 months	12-15 months	12-18 months
DTaP	1	2	3		4
HIB	1	2	3[1]	3 or 4	1[2]
Hep B	1	2	3[3]		
Polio	1	2	3[4]		
MMR				1[5]	
C'pox[6]					1[5]

[1] Dose 3 at 6 months not needed if three dose HIB (PedVax) or HepB/HIB (Comvax) vaccine is used. Contact the child's vaccine provider if there is a question regarding this vaccine.

[2] If HIB#1 given at after 15 months of age meets requirements.

[3] If Hep B/HIB (Comvax) vaccine is used, the 3rd dose will be administered at 12, not 6 months. Contact the child's vaccine provider if there is a question reguarding this vaccine.

[4] The 3rd dose of Polio vaccine is usually given at 6 months of age, but may be given as late as 18 months of age.

[5] Usually given at 12 months of age.

[6] Parent or Physician diagnosis of chickenpox meets requirements.

III. Current Immunization Record:

(If completing manually, please record the date (M/D/Y) of each dose received.)

Vaccine	First	Second	Third	Fourth	Fifth
DTP/DTaP/DT/Td					
HIB					
Hepatitis B					
Polio					
Measles/Mumps/Rubella (MMR)					
Varicella (chickenpox)		*Or date of chickenpox disease:*			
S.Pneumo					

Date Next Immunization(s) Due _____

IV. Certifications:

A. **Immunization:** *This child has received the immunizations required for child care attendance or has been granted a Medical Exemption as evidenced by the attached statement describing that exemption*

_____ _____ _____

Medical Provider's Name Medical Provider's Stamp or Signature Date

B. **Health Examination:** (required for childern aged 8 weeks to 30 months in child care)

_____ _____ _____

Medical Provider's Name Medical Provider's Stamp or Signature Date